STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 90379-001**

v

Physicians Health Plan of Mid-Michigan
Respondent
_____/

Issued and entered
This 9th day of September 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On June 12, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* On June 20, 2008, the Commissioner accepted the request.

The issue in this external review can be decided by a contractual analysis. The contract is the certificate of coverage (the certificate) issued by Physicians Health Plan of Mid-Michigan (PHPMM). The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in the certificate. The certificate provides for both network and non-network benefits. To obtain network benefits, the care must be provided

by a network provider. Care from non-network providers may be covered but it generally comes with

a higher out-of-pocket cost for the PHPMM member. The certificate permits network-level benefits for out-of-network services when the services are not available from network providers or in an emergency.

The Petitioner was diagnosed with breast cancer and had a mastectomy. She requested authorization for breast reconstruction surgery of the left breast utilizing the DIEP flap (or "stacked" flap) procedure and asked that it be performed at the XXXXX in XXXXX (the Center). The Center and its doctors are not part of PHPMM's network and PHPMM denied the Petitioner's request that their services be covered at the network level.

The Petitioner appealed the denial and after exhausting its internal grievance process received PHPMM's final adverse determination dated May 12, 2008.

III
ISSUE

Did PHPMM properly deny coverage for the Petitioner's reconstructive surgery at the network level?

IV
ANALYSIS

Petitioner's Argument

The Petitioner explained why she requested authorization and coverage for reconstructive surgery at the Center:

> I want to have the DIEP Flap procedure because it uses skin and fat from the abdomen without the loss of abdominal muscle. I consulted plastic surgeon, Dr. XXXXX, and he told me that no one in Michigan does this procedure. However, oncologist Dr. XXXXX of the XXXXX told me that he had a patient who went to the XXXXX in XXXXX to have DIEP and was very satisfied with it. I have sent photos to this clinic and their surgeon…has determined that I would need a "Stacked Flap DIEP." The staff at the Center believes that they are the only provider in the country to do the "stacked flap." The doctors in this clinic have 15 years of combined experience in performing this type of breast reconstruction and do 7-10 procedures a week. For these reasons, I would choose them to do my surgery. [Underlining in original]

The Petitioner says that although PHPMM sent her a list of doctors who perform breast reconstruction, none of them performs the DIEP. She searched the web and found that Dr. XXXXX at the XXXXX performs the DIEP but the Petitioner could not initially find out how many she has performed; she was later informed that Dr. XXXXX has performed a "handful" successfully but there was no mention of the DIEP procedure on the university's website.

The Petitioner argues that she should be allowed network coverage for the reconstruction at the Center:

> I believe [the DIEP flap] is the most natural approach to breast reconstruction and has the least likelihood of complications in the short and the long term. PHP is denying coverage for me to have the surgery at the Center XXXXX because they claim that I can have the DIEP Stacked Flap surgery within the PHP network. However, I believe that is not possible for the following reasons:
>
> 1) The Center XXXXX in XXXXX is the only clinic in the country to do the DIEP Stacked Flap.
>
> 2) The XXXXX where DIEP Flap surgery is reportedly performed is also seemingly out-of-network. If PHPMM can make one-time contract with U of M, why are they not willing to negotiate with The Center XXXXX?
>
> 3) I would willingly go to a doctor in-network who had the same qualifications and experience as the doctors in XXXXX, but I'm not satisfied that either Dr. XXXXX or Dr. XXXXX has these attributes. Until the time that DIEP Flap surgery becomes more widely available by qualified and experienced practitioners, the clinics that specialize in it are going to be the safest and possibly most economical in the long run, due to low incidence of complications and unfavorable outcomes.

The Petitioner therefore believes PHPMM should cover the services at the network level because the DIEP surgery is not available within the PHPMM network and the Center has special expertise.

Physicians Health Plan's Argument

In its May 12, 2008, final adverse determination, PHPMM said it denied the Petitioner's request because "the requested services are available within the PHPMM network." PHPMM cites these provisions in the certificate:

Section 1: What's Covered – Benefits

Accessing Benefits
You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits, Covered Health Services must be provided by a Network Physician or other Network provider in the Physician's office or at a Network facility. For facility services, Network Benefits apply to Covered Health Services that are provided at a Network facility by or under the direction of either a Network or non-Network Physician or other provider. For details about when Network Benefits apply see Section 3: Description of Network and Non-Network Benefits.

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Section 3: Description of Network and Non-Network Benefits

Network Benefits
Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Service which are:

- Provided by or under the direction of a Network Physician in a Network Physician's office or at a Network facility.

- Emergency Health Services.

- Urgent Care Center services.

* * *

Health Services from Non-Network Providers Paid as Network Benefits
If we determine that specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us, and we will work with you and your Network Physician to coordinate care through a non-Network provider. You are responsible for verifying that we have approved the request. If you see a non-Network provider without verifying in advance that we have approved your visit, Network Benefits will not be paid. Non-Network Benefits may be available if the services you receive are Covered Health Services for which Benefits are provided under the Policy.

Non-Network Benefits
Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services which are any of the following:

- Provided by a non-Network Physician or other non-Network provider.

- Provided at a non-Network facility.

PHPMM says the services the Petitioner needs are available within its network. In a letter dated April 1, 2008, PHPMM provided the Petitioner with the names of surgeons in its network that do breast reconstruction after a mastectomy. PHPMM also advised the Petitioner that she could use her non-network benefits for care at the Center; however, that would require satisfying a $250.00 deductible and then paying 20% coinsurance.

Based on the language in the certificate, PHPMM believes that it appropriately denied coverage at the network level.

Commissioner's Review

The certificate has two levels of benefits and the Petitioner can receive medically necessary and covered services from either network or non-network providers. Services from a non-network provider may be covered at the network level under certain circumstances, e.g., services for urgent or emergency care, or when PHPMM does not have the needed care available within its network.

It is the Petitioner's contention that the particular surgical procedure she needs (i.e., the DIEP flap or stacked flap) is not available within PHPMM's network. The Commissioner recognizes that a patient might have a preference for a specific procedure or treatment. In this case, the Petitioner believes that the DIEP flap or stacked flap procedure would be best for her. However, PHPMM has identified several physicians in its network and its expanded network (which includes the University of Michigan) who are capable of performing reconstructive procedures. In a May 2, 2008, letter, PHPMM confirmed that the DIEP flap procedure is performed at the University of Michigan.

The Petitioner also argued that the Center has greater expertise to perform the surgical procedure she wants than any of PHPMM's network providers, and she presented some evidence to show the Center's experience. Even PHPMM, on its website, recognizes that experience in performing certain procedures can be a factor in selecting a physician. However, even if it is true that the Center has had more experience with the procedure the Petitioner seeks, the

Commissioner

has no basis for concluding that experience alone would require PHPMM to cover the Petitioner's care there when it has qualified providers in its network.

The record here does not establish that PHPMM's network surgeons are not able to provide the Petitioner's medically necessary services. The Commissioner therefore finds that PHPMM's determination of benefits was appropriate; it is not required to cover any services from the Center at the network level.

V
ORDER

The Commissioner upholds PHPMM's final adverse determination of May 12, 2008. PHPMM is not required to provide network level coverage for the Petitioner's requested services from the non-network provider the Center XXXXX.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.